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ABSTRACT

American Indians experience many problems related to alcohol misuse. However, there are prevention approaches that work to reduce risk of alcohol misuse among American Indians. With regard to the way prevention workers carry out their work in American Indian communities, programs must emerge from the community, prevention workers must demonstrate a commitment to the community, and non-community members need to develop cultural sensitivity. Developing cultural sensitivity involves first becoming aware of one's own cultural values and learning about differences relative to other cultures, and then spending time in a community. When negotiating program access with American Indian communities, it is important to demonstrate how the community will benefit from the program. Regarding prevention approaches that are most appropriate in American Indian communities, several principles emerge: using American Indians as staff whenever possible, and incorporating cultural concepts within the programs. Because American Indian culture varies across communities, it is important to design programs that are relevant to local norms, values, and conditions. Prevention programs should empower people by enabling participants to identify with and function in their community and the dominant society, and by assuring that individuals in the community can continue the programs. A comprehensive community program should involve a variety of approaches that fit together in a mutually supportive and beneficial manner and strengthen the community and family, not just individuals. Finally, programs must ensure that the interventions are adequate and maintain fidelity across sites. (Contains 95 references.) (TD)

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2

Prevention Principles for American Indian Communities

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Abstract

As a group, American Indians experience many problems related to alcohol misuse. Age of first involvement with alcohol is younger, frequency and amount of drinking is greater, and negative consequences are more common for American Indians than for non-Indians. However, there are prevention approaches that work to reduce risk of alcohol misuse among American Indians. Based on an examination of these approaches, this chapter identifies prevention principles that may increase the likelihood of success when working with American Indian communities. These principles relate first to the ways that prevention workers carry out their work in American Indian communities and second to types of strategies used in the prevention programs. The concern in both areas is to identify general principles that are appropriate for American Indian communities.

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The purpose of this chapter is provide an overview of some of the typical prevention efforts that have taken place in American

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Indian communities and to identify common themes or *best practices* among them. These practices fall into two areas. The first area addresses the manner or process by which prevention workers carry out their work in American Indian communities. The second area relates to the content of the prevention efforts. The concern in both areas is to identify specific principles that are appropriate for American Indian communities.

Although this chapter focuses on programs for the prevention of alcohol misuse, the issues addressed apply generally to the prevention of all drug misuse. This is important since drugs other than alcohol present major problems in American Indian communities. Recent work by Okwumabua and Duryea (1987); Swaim, Oetting, Edwards, and Beauvais (1989); Beauvais (1992a), and Mail and Johnson (1993) provide good overviews of the range of drugs and related problems experienced by American Indians. For example, inhalants are frequently abused by American Indian youth, especially by young adolescents before they gain access to alcohol (Beauvais, Oetting, & Edwards, 1985a; Wingert, 1982); use of marijuana is highly variable across different American Indian groups, but appears to be higher among American Indian youth than non-Indian youth (Mail & Johnson, 1993); heroin use is very low among American Indian people (Bachman et al., 1991); and cocaine use is similar for American Indians and non-Indians (Beauvais et al., 1985a). After reviewing the evidence from several national studies, Mail and Johnson (1993) concluded that the availability and predictability of effects have made and continue to make alcohol the drug of choice among American Indian people.

This chapter begins with an overview of population characteristics that provide important background information for prevention workers planning to work with American Indians. Next, the extent of the problem of alcohol misuse is described. Third, how prevention work is carried out in American Indian communities is examined in an effort to identify principles that will guide workers in carrying out successful programs. Finally, several prevention approaches are reviewed for the purpose of drawing out some of the practices that are emphasized in American Indian programs.

The American Indian Population

As of 2000, there were 557 federally recognized tribes (Indian Health Service [IHS], 1999). While some similarities exist among these groups, there is also significant variation as evidenced by many distinct cultural areas (Manson, Shore, Barron, Ackerson, & Neligh, 1992) and more than 200 currently spoken American Indian languages (Fleming, 1992). Persons defined as American Indians may also differ greatly by degree of Indian ancestry, with 25 percent American Indian blood the most commonly accepted minimum threshold for tribal membership (Wilson, 1992).

All of this is further complicated because, like members of other ethnic groups, most American Indians live in two worlds: their own ethnic community and the mainstream or white community. This experience of dual socialization has been conceptualized as primary enculturation experiences within one's own cultural group along with less comprehensive, but significant exposure to agents and forces within the majority culture (de Anda, 1984). Valentine (1971) pointed out that all ethnic minority groups are exposed to dominant cultural patterns by mainstream institutions, including the mass media, advertising, public schooling, and national holidays and heroes. Another layer of American Indian diversity is intertribal and interracial marriages that may result in many American Indian people affiliating with more than one tribe, being of mixed blood, or both. Indeed, throughout the 20th century, mixed-blood American Indians have outnumbered full-blood Indians (Wilson, 1992).

Geographically, American Indian populations tend to cluster in the Western States with 66 percent of all American Indians living in 10 States. Of these 10, 8 are in the West or Midwest (Hodgkinson, Outtz, & Obarakpor, 1990; Snipp, 1989). While American Indian people are often thought of as residing on isolated reservations, the majority live in urban environments or migrate to and from reservations and urban areas (Hirschfelder & Montano, 1993; U.S. Census Bureau, 1992). Finally, as a result of a birth rate that has consistently been twice that of the U.S.

average, the American Indian population is young. The median age of the American Indian population was 24.2 years in 1990, compared with 34.4 years for U.S. whites (IHS, 1993).

Extent of the Problem

Alcohol misuse leads to a number of problems for many American Indian communities. For example, as a group, American Indians and Alaska Natives experience high rates of heart disease, cancer, diabetes, and injuries and death due to accidents (IHS, 1991). Alcohol misuse plays a significant role in all of these problems. Both inpatient and outpatient data of the IHS show alcohol-related trauma and diseases to be frequent reasons for health care and disability (Hisnanick & Erickson, 1993; IHS, 1993).

Further, American Indians have a higher rate of alcohol-related death than the general U.S. population. For example, in the age group 25 to 34, American Indian males die 2.8 times more frequently than non-Indian males from motor vehicle crashes; 2.7 times more frequently from other accidents; 2.0 times more frequently from suicide; 1.9 times more frequently from homicide; and 6.8 times more frequently from alcohol dependence syndrome, alcoholic psychosis, and chronic liver disease and alcoholic cirrhosis combined (May, 1995). In summary, alcohol is a major factor in 5 of the 10 leading causes of mortality for American Indians (IHS, 1992). American Indian males have a greater problem with alcohol-involved death than American Indian females; alcohol-involved mortality data are worse for both American Indian males and females than the overall U.S. averages; and the disparity between American Indians and the U.S. general population is greatest in the younger age groups (May, 1986, 1989).

Much of the American Indian-related alcohol research concentrates on young persons and an examination of some of these findings can be instructive regarding appropriate prevention efforts. American Indian youths generally report that they use alcohol as frequently or more frequently than other youths in the

United States. For example, by the 12th grade, lifetime prevalence of alcohol use is quite high: 96 percent for American Indian males and 92 percent for females (Oetting & Beauvais, 1989). But the major difference between American Indian youth data and U.S. youth averages is found in measures dealing with age at first involvement and degree of involvement. Age at first involvement with alcohol is younger for American Indian youths, frequency and amount of drinking are greater, and negative consequences are more common and severe (Beauvais, Oetting, & Edwards, 1985b; Forslund & Cranston, 1975; Forslund & Meyers, 1974; Hughes & Dodder, 1984; Oetting, Beauvais, & Edwards, 1988). Oetting and colleagues (1989) have found that at all ages and grades, a greater percentage of American Indian youth are more heavily involved with alcohol than are non-Indians. Several studies indicate that heavy drinking is both encouraged and expected among many peer groups as the "Indian thing to do" (Winfree & Griffiths, 1983a). Beauvais and LaBoueff (1985) indicate that the youth most likely to abuse alcohol are those tied to alcohol and drug abusing peer clusters. By 12th grade, 80 percent of American Indian youth are current drinkers, but there is some variation from reservation to reservation (May, 1982). Severity measures show that American Indian youths who drink are more likely to report having been drunk and to have "blacked out" (Oetting & Beauvais, 1989). Just as U.S. high school data show an increase in drinking and marijuana use through 1980, and subsequent declines after 1980, the American Indian patterns over time are similar. That is, American Indian youths have reported reduced use of drugs and alcohol in recent years (Oetting & Beauvais, 1989; Winfree & Griffiths, 1983b). However, the subgroup of American Indian youths who indicate heavy use has not declined but rather has remained steady at 17 percent to 20 percent (Beauvais, 1992a).

Ferguson (1968) has described the majority of American Indian drinking as recreational drinking. She indicated that the subgroup of recreational drinkers is typically made up of young males who drink with friends for weekends, parties, special occasions, and other social events. As with other groups of young persons, drinking and intoxication are important for

social cohesion and are generally highly valued. This type of recreational drinking among American Indian groups of many tribes may differ from some other groups in the United States only in matters of degree and cultural meaning. As described by many authors, American Indian recreational drinking is more rapid, more forced, and the "bouts" are extended over long nights, entire weekends, and for other lengthy periods (Dozier, 1966; Hughes & Dodder, 1984; Lurie, 1971; Savard, 1968; Weisner, Weibel-Orlando, & Lang, 1984). Very high blood alcohol concentrations are commonly found in American Indians who participate in this style of drinking.

Both the data on the extent and the consequences of use clearly point to the need for programs for preventing alcohol-involved problems, especially among American Indian youth. Differences by tribal group, cultural orientation, degree of American Indian ancestry, and reservation or urban residency prohibit the prescription of what prevention should look like in all American Indian communities. However, by examining approaches to working in American Indian communities and the range of prevention programs operating in these communities, it is possible to arrive at some prevention principles that are applicable for working with American Indians.

Working in Indian Communities

Overcoming Distrust

One of the first issues to consider in understanding the dynamics of carrying out prevention programs in American Indian communities is that like many other ethnic minority communities, American Indian communities often have a historical distrust of the dominant society (Lockart, 1981). This distrust is based in the historical nature of the relationship between the dominant culture and American Indians that includes a 500-year history of oppression and domination—at times approaching genocide. When the programs are seen as imposed from outside the community, this distrust is likely to escalate and to form a significant barrier. In such situations, prevention programs are

not likely to produce useful results. To overcome this, we must find ways to make programs relevant to communities and we must demonstrate our commitment to the community. A key part of making programs relevant is to have them emerge out of the process of community involvement. Beauvais and LaBoueff (1985) present a model of community action that progresses from a few interested people to a core group to a community task force. Each step involves more community members committed to the idea of prevention.

There are several ways that noncommunity members can demonstrate their commitment to American Indian communities (Fred Beauvais, personal communication, August 15, 1997). Simply responding to the stated needs that are defined by the process of community involvement instead of having a set program that is defined by academic interests or by government or foundation announcements is a strong statement to the community. Providing technical assistance that is needed in the community even though it may not be funded directly by grants also contributes to demonstrating a commitment. Perhaps most important, prevention workers need to be willing to stick around and deal with a problem for as long as it takes, even if that means moving beyond the original funding period. This might mean locating and securing additional funding in order to continue a program. In summary, working in American Indian communities requires us to directly address issues of distrust by listening to and then responding in a committed manner to community-defined interests.

Developing Cultural Sensitivity

To accomplish the above, we must be culturally sensitive. But what does that really mean? Much work has been done concerning the overall issues of cultural diversity and cultural sensitivity. Tello (1985), Cross (1988), Cardenas (1989), and Orlandi (1992) refer to this area of work as cultural competency. While varying slightly, these authors view competency as occurring in stages with simple awareness of cultural differences being a necessary first stage. The second stage is self-assessment, that

is, the awareness of one's own cultural values. This approach to cultural competence holds that people must understand their own culture (i.e., recognize that they have a cultural lens) before they can be sensitive to other cultures. The third stage is an understanding of the dynamics such as conflict and racism that may occur when members of different cultures interact. Working through these three stages enables individuals to adapt to diversity and to adjust professional skills to fit within the cultural context of the ethnic community. Green (1982) clarifies this process by pointing out that to be culturally competent means to conduct one's professional work in a way that is congruent with the behaviors and expectations that members of a cultural group recognize as appropriate among themselves. He states that it does not mean that nonmembers of a community will be able to conduct themselves *as though* they are a member of the group. Rather, they must be able to engage the community on something other than their own terms and demonstrate acceptance of cultural difference in an open, genuine manner, without condescension.

To expand on this issue, the term culture must be given substance. Lum (1986) summarizes many of the ideas concerning culture. He indicates that culture deals with the social heritage of humans. Culture is the way of life of a society: prescribed ways of behaving or norms of conduct, beliefs, values, and skills. It is the sum total of life patterns passed on from one generation to the next within a group of people. Culture is a code that guides interpretation of behavior. Orlandi (1992, p. vi) puts it this way, "culture is the shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people."

From the above it is clear that culture is not static but is constantly being altered. Indeed, cultures can be viewed as living, evolving systems where over time some cultural traits remain, some change, and others are discarded (Attneave, 1989). A common, albeit, limited view of cultural change is that it occurs along a single continuum from "traditional" to "modern." Drawing attention to this perspective is important both because it is common and because it can lead to the devaluing of

American Indian culture (Beauvais, 1989). Inherent in this linear view of cultural change is the idea that people move from the old to the new and that while in transit, they are confused—experiencing stress and in general not able to function competently. Something of the old is lost when one embraces the new. These themes of loss, confusion, and stress emphasize the negative aspects of cultural change and represent a limited view. In other words, this view of cultural change as occurring along a single continuum from traditional to modern contributes to a lack of cultural sensitivity.

A promising alternative view of cultural change is the concept of biculturalism. Biculturalism is the ability to function effectively in the mainstream culture and yet maintain positive and significant cultural connections to the ethnic community. Oetting and Beauvais (1990–91) refer to this approach as "orthogonal cultural identity" with the term *orthogonal* drawing attention to the idea that people are capable of identifying independently with more than one culture. McFee (1968) describes how some American Indians in his research shifted their frame of reference when interacting with whites and then shifted back again when dealing with members of their Blackfeet community. He formed the metaphor of *150% man* to point out that for his respondents, cultural change was not a journey of loss but rather one of gain. The bicultural approach introduces the possibility of increased cultural sensitivity because it allows equal treatment and coexistence of cultures rather than requiring the movement from traditional to modern. The bicultural view is particularly important in work with urban American Indian communities where by necessity community members live in two worlds—their Indian culture and the mainstream or dominant culture.

To be culturally sensitive, one needs to gain an understanding of the meaning of the institutions, values, religious ideals, habits of thinking, artistic expressions, and patterns of social and interpersonal relationships that influence the lives of the members of the community in which the research is to take place. Clearly this is not a simple task and how well nonmembers of a culture can accomplish this may vary. However, the

alternative of ignoring culture in working with American Indian populations relegates our efforts to be of little importance to these communities.

A useful starting point in thinking about cultural sensitivity is to focus on values. Some authors have developed typologies that compare dominant and other, primarily ethnic, cultural values. Randall-David (1989) compares common values of "Anglo" and "Other Ethnocultural" groups. In general, this typology fits well with the values found in many American Indian communities. She indicates that "Anglos" value mastery over nature, doing, and individualism, while other groups value harmony with nature, being, and group welfare. It is important to note that this approach treats culture as a dichotomy, comparing white values with the values of other cultural groups. Although there are indeed many similarities among broad cultural groups of American Indians, this typology and others like it carry the risk of lumping together all white and all American Indian cultures and attempting to treat them as if there are only two large cultural groups. The limitation of this is apparent when one considers the diversity in tribal affiliation, language, degree of American Indian ancestry, and reservation or urban residence that is found in the American Indian population.

So why use such a framework at all? Taking these cautions and limitations into account, this dichotomous approach remains useful as an overview in helping to sort out possible areas of cultural difference. It draws attention to the idea of differences and gives prevention workers direction in understanding the meaning of culture for themselves and for their target populations. Use of such frameworks can be of assistance in working through the first two steps of cultural competency, those of acquiring an awareness of cultural differences and becoming aware of one's own culture. In other words, this approach is a reasonable starting point for more in-depth inquiry into the issue of cultural sensitivity.

After this starting point of examining differences in cultural values, what comes next? Given the range of cultures that exist and the amount and kind of knowledge that is necessary in

order to carry out prevention work in a way that is compatible with the culture of the American Indian community, how can workers attain more depth in terms of cultural sensitivity? The simple answer is: Because the culture of each community varies, there is no substitute for direct and extended involvement. However, gaining access to a community is not always an easy task. In American Indian communities, one of the first steps in gaining access is to describe the intent, nature, and benefits of a possible project before the governing body (Beauvais & Trimble, 1992). On reservations, identification of the governing body is clear-cut and is normally the Tribal Council. Urban American Indian communities do not have a governing body; however, a parallel step might mean meeting with a group composed of representatives from the major American Indian organizations. In addition, a community meeting open to all American Indian people could be used to explain the purpose, costs, and benefits of the program. It is important to note that the purpose of such meetings is both to show respect for the community by presenting ideas about proposed work and, perhaps more important, to obtain feedback from the community. The point of this process is that a significant part of being cultur-ally sensitive is to have the sanction of the community. Without the sanction, whether it is formal or informal, noncommunity members will always be seen as outsiders and hence be frustrated in further attempts to establish credibility.

In addition to obtaining community support, culturally sensitive prevention work involves the community in the actual process from start to finish (Davidson, 1988). The prevention team might include the technical program people, a broadly constituted steering committee, and local colleagues (Mohatt, 1989). To every extent possible, community members should be employed as part of the team. This team should then meet as a group throughout the program to determine and monitor the specifics of implementation, of explanations to the community, and of reporting results.

While not addressing prevention programs directly, Shore (1989) outlined many of the steps necessary for culturally sensitive work in American Indian communities. The elements of his

schema include the following: (1) the planning should begin with collaboration with the community; (2) the focus of the work should be compatible with local priorities; (3) the design and selection of a particular program approach should consider the relevance of the outcome for use by the community; and (4) the program should be implemented in a local community partnership with an attempt to employ community members as staff whenever possible. Again, the community action model proposed by Beauvais and LaBoueff (1985) incorporates all of these ideas and can certainly be instructive for prevention workers contemplating work in American Indian communities.

Approaches to Prevention

In a review of more than 50 programs that have been implemented in American Indian communities, May and Moran (1995) identified many issues that can guide prevention efforts. Generally the prevention literature is divided into tertiary, secondary, and primary prevention. Because there are different interpretations of these terms, it is important to clarify that this chapter will use these categories as defined by Last (1983). *Tertiary prevention* consists of measures taken to reduce existing impairments and disabilities and to minimize suffering caused by severe alcohol misuse or alcohol dependence. *Secondary prevention* uses measures available to individuals and populations for early detection within high-risk groups and for prompt and effective intervention to correct or minimize alcohol misuse in the earliest years of onset. *Primary prevention* is the promotion of health and elimination of alcohol abuse and its consequences through community-wide efforts, such as improving knowledge; altering the environment; and changing the social structure, norms, and values. Use of these categories allows the consideration of diverse programs that focus on different but related aspects of the problem. The programs described here were selected because they demonstrate the many approaches used in American Indian communities. Some of what is in place

is distinct to American Indian programs while much is common to prevention programs in other communities as well.

Tertiary Prevention

Given the magnitude of the problems related to alcohol misuse that exist in many American Indian communities, programs that emphasize tertiary strategies with alcohol abuse are important parts of an overall prevention strategy. Although secondary and primary strategies may hold the ultimate hope for healthy communities, we cannot ignore the problems of those currently alcohol-dependent.

Weibel-Orlando (1989) describes some of the typical methods used in tertiary prevention programs with adult American Indian alcoholics. She reports on a survey of 26 federally funded rural and urban treatment programs and compares them across factors such as ethnicity of staff, strength of affiliation with Alcoholics Anonymous (AA), cooperation with tribal healers, and treatment effectiveness. Most of the staff in the surveyed programs were American Indian. This was seen as positive, because non-Indian counselors often faced reactions ranging from overt hostility to sullen resistance. Most of the programs had a strong AA affiliation; however, this was seen as primarily related to the AA background of almost all of the counselors. Finally, most of the programs were accommodating to cultural practices. On the low end, this involved the display of American Indian posters and handicrafts, while programs with more cultural involvement often included such things as sweat lodges and use of a sacred pipe during prayer ceremonies. However, traditional American Indian healers played only a minor role in the 26 programs. Weibel-Orlando states that several of the medicine men she interviewed expressed doubt that traditional healing practices are appropriate in typical treatment settings and that most traditional healing is tribal-specific and not available to outsiders. She concludes by calling for a more local focus for treatment programs, in order to enable increased cultural involvement.

Jilek-Aall (1981) describes some modifications made to the traditional AA approach that appeared to have success with the Coast Salish people of the Northwest. For example, rather than being limited to the recovering person, attendance at meetings was open to other family and community members. In addition, participants were free to come and go as they chose and when speaking were encouraged to talk as long as they wanted. This more open structure allowed tribal participants to incorporate cultural activities as part of the program. Others (Coggins, 1990; personal communication, February 9, 1998) have developed cultural approaches that directly tie the 4 directions of the medicine wheel to the 12 steps of AA.

In a similar vein, Albaugh and Anderson (1974); Pascarosa and Futterman (1976); and Blum, Futterman, and Pascarosa (1977) describe Native American church practices and peyote as therapeutic agents that can treat problems with alcoholism. These authors describe the therapeutic efficacy of using the values, beliefs, structure, and rituals of the Native American church to treat and prevent further problems that result from alcoholism.

Watts and Gutierres (1997) interviewed American Indian clients at three residential treatment facilities in Arizona. This qualitative work focuses on clients' views of the recovery process. A major theme from this study is the importance of family and community. For many of the participants it was the intervention of significant members of their family and community networks that facilitated their entry into treatment. During the treatment programs, elderly family or community members were often cited as more important to recovery than the program counselors. The lesson for prevention programs is that practices such as talking circles, sweats, and powwows should be structured in such a manner as to facilitate active involvement of the American Indian clients' networks.

Ferguson (1976) explores the use of stake theory to understand the outcomes of a treatment study of Navajo chronic alcoholics. This is a fairly straightforward theory that holds that those who have a stake in society will conform to society's norms and demonstrate less deviance such as alcohol misuse. She

found that those with a stake in the Navajo society or a stake in Western society responded better than participants with a stake in neither. However, those with a stake in both Navajo society and Western society had the most treatment success. One possible explanation of these results is based on the work of Lewin (1948), who indicates that individuals require a strong sense of group identification to maintain a state of well-being. Ethnic identity is a critical component of group identification and is considered by many as crucial to self-concept and psychological functioning (Gurin & Epps, 1975; Maldonado, 1975). In a sense, having a stake in a segment of society is similar to identifying with that segment. Oetting and Beauvais (1990–91) found that American Indian respondents who did not identify strongly with any ethnic group (marginalization) tended to score low on psychological measures of well-being; those who identified with either their ethnic group or mainstream white society (separation or assimilation) scored higher; and those who strongly identified with both their ethnic group and the mainstream society (biculturalism) tended to have the highest scores.

Similarly, Moran, Fleming, Somervell, and Manson (1996), in a study of nine high schools located in American Indian communities, sorted American Indian adolescents into low and high identity on the basis of their identification with both American Indian and white cultures. The result was four groups: (1) low identification with both American Indian and white cultures; (2) high identification with American Indian culture only; (3) high identification with white culture only; and (4) high identification with both American Indian and white cultures. The relation of those four groups to psychological well-being as defined by the respondents' perceptions of their social competencies, personal mastery, self-esteem, and perceived social support was examined. For all of the measures of positive psychological well-being, the mean values across the four groups were different at statistically significant levels. Further, the lowest scores occurred for those with low identification with both American Indian and white cultures, middle range scores were obtained by those with high identification with only American Indian or only white culture, and the high-

est scores occurred for those with high identification with both American Indian and white cultures. The implication of this work by Ferguson (1976), Oetting and Beauvais (1990–91), and Moran et al. (1996) is that programs at all levels of prevention (tertiary, secondary, and primary) can probably benefit by consciously addressing issues of culture in a manner that fosters stronger identification and thus enhances participants' stake in both their American Indian society and Western society.

Secondary Prevention

A majority of the secondary prevention programs aimed at American Indians in recent years have been school-based initiatives that emphasize information about the effects and consequences of substance abuse. Programs such as "Here's Looking at You," "Project Charley," and "Babes" have been used in many American Indian communities, both on and off reservations (May & Moran, 1995). The consistent themes in school-based substance abuse prevention programs are building bicultural competence (LaFromboise and Rowe, 1983), increasing self-esteem and self-efficacy (IHS, 1987), improving resistance to peer pressure and overall discriminatory and judgment skills (Duryea & Matzek, 1990; Gilchrist, Schinke, Trimble & Cvetkovich, 1987; Schinke, Orlandi, Botvin, Gilchrist, Trimble, & Locklear, 1988; Schinke, Schilling, Gilchrist, Asby, & Kitajima, 1989), and increasing the perception of the riskiness of alcohol and drug use (Bernstein & Woodall, 1987). The current literature supports these approaches if they are undertaken in combination. That is, building self-esteem alone is not likely to reduce alcohol use, while building new perceptions, values, skills, and support systems along with increasing self-esteem may be beneficial. Newcomb and Bentler (1989) indicate that in addition to single targets such as self-esteem, these programs must also affect the social and cultural aspects of life and mitigate peer group pressure. This can be accomplished by either direct or indirect influence, but the sociocultural aspects must be addressed in addition to the mental health and psychological issues (Oetting & Beauvais, 1989).

Moran (1999) reports on a secondary prevention program that targeted urban American Indian youth. The program was conceptualized and based on two sources of expertise. It built directly on the prevention research and it also involved the local American Indian community through a process of community meetings and focus groups. From the literature came the general approaches of (1) correcting inaccurate stereotypes that overemphasize the amount of alcohol use; (2) developing a conflict between personal values and alcohol use; (3) enhancing self-esteem; (4) teaching a structured way for making good decisions; (5) learning and practicing skills to resist peer pressure; and (6) making a personal commitment to not use alcohol. These approaches were chosen because they have demonstrated effectiveness across ethnic groups (Hanson, 1993).

In order to address culture in a meaningful way, the local American Indian community was systematically involved in identifying a unifying theme for the program. Meetings with various groups of American Indian people were held to discuss what was needed in the community and to provide details about the study. This process resulted in a name for the project: the Seventh Generation. From an American Indian cultural perspective, this is more than just a name. Among the Lakota, who represent the majority of American Indian people involved in the meetings, the phrase refers to a time of healing, a time for American Indian nations to come together. Today's American Indian children are considered to be the seventh generation. Thus, using this name for an alcohol prevention program targeting American Indian youth carries a powerful message within the community.

A second meaning of the term derives from placing the children in the center of seven generations. For American Indian people this conceptualization fits well with prevention efforts. Namely, children must remember the wisdom of their elders (parents, grandparents, and great-grandparents) when making decisions and they must also consider the impact of their decisions on those who will come after them (children, grandchildren, and great-grandchildren). This multigenerational view fits

well with the concept of responsible decision making and became the focal point for much of the program.

In addition to the program's name, the up-front involvement of the community also resulted in a way to incorporate American Indian culture in a manner that was meaningful to urban American Indians. After several meetings an agreement emerged that a set of core values transcended tribal differences. After generating a list of more than 20 values, the participants narrowed the list to 7: Harmony, Respect, Generosity, Courage, Wisdom, Humility, and Honesty. These values reflect many American Indian cultural concepts such as the *Medicine Wheel* of the Northern Plains or the Navajo terms *Hozho* and *Walk in Beauty*. Thus, rather than using cultural artifacts such as the teaching of American Indian arts and crafts, the Seventh Generation Program was developed in a manner that incorporated cultural values as the core organizing framework for the program. The parallel paths of development (i.e., utilizing both the prevention literature and key knowledge from the community) exemplify the principle of meaningful community participation in the development and implementation of prevention programs.

Primary Prevention

The philosophy of primary prevention among American Indian people calls for broad programs of health promotion, particularly those that emphasize community change. May (1986) stresses primary prevention through social policy, environmental change, and broad-based action for normative change. The Office of Substance Abuse Prevention (OSAP, 1990) focuses on both mental health and substance abuse programs for prevention and concludes with an emphasis on comprehensive prevention. Mail (1985) lays out a rationale and a number of specific considerations for primary prevention initiatives in American Indian communities, while Mail and Wright (1989) indicate that successful prevention programs will have to come from the communities themselves.

Beauvais (1992b) pinpoints socioeconomic conditions as the major factor that has contributed to substance abuse in American Indian communities. He proposes an integrated model of prevention that focuses on improvement in (1) social structure (economics, family structure, and cultural integrity); (2) socialization (family caring, sanctions, and religiosity); (3) psychological factors (self-esteem and reduced alienation); and (4) peer clusters (peer encouragement for nonuse and sanctions against alcohol and drug use). Beauvais believes that this will ultimately lead to lower levels of alcohol and drug use. This is similar to the work of Beauvais and LaBoueff (1985), in which the comprehensive community action approach is advocated, an approach that should be implemented in a collaborative manner from within the community rather than from the top down.

Beauchamp (1980) reiterates the community focus in a four-step approach to the process of primary prevention in American Indian communities. First, there should be a focus on building consensus around which aspects of alcohol-related behavior can and must be addressed for the benefit of the larger community. Second, a definition of safe or nonproblematic drinking patterns should be developed. This is an important step since nonproblematic drinking is not an appropriate target for prevention efforts. Third, approaches to reduce unsafe drinking practices and encourage nonproblematic practices should be planned and carried out. Fourth, there should be a focus on broad community support for all efforts at reducing unsafe drinking practices. Beauchamp's point is that both problem definition and solution should be collective efforts.

May (1992) provides an overview of several specific primary prevention strategies that can be used. First is the regulation of alcohol supply through raising taxes, limiting and controlling the number and types of alcohol outlets, enforcing strict age limits on alcohol use, discouraging advertising targeted at vulnerable groups, and enforcing current reservation laws. This latter point deserves further comment. Until 1953, Federal law prohibited alcohol on all reservations and since that time only about 30 percent of reservations have voted to allow alcohol. In other words,

prohibition continues on approximately 70 percent of current reservations. Strict enforcement of such laws might reduce the level of alcohol-related problems. On the other hand, prohibition does not seem to have worked well since bootlegging is common on dry reservations and availability of alcohol at off-reservation sites often results in an increase in the risk of intoxicated driving. An argument can be made that a more rational policy would be legalization of alcohol with strict and enforceable guidelines focused on reducing unsafe drinking practices.

The second strategy presented by May (1992) focuses on this last point, namely, reducing unsafe drinking and promoting safe and appropriate drinking. Drinking behaviors that communities have found unacceptable are driving under the influence, chronic intoxication, alcohol-related violence, public inebriation, and alcohol consumption by pregnant women. Laws limiting each of these behaviors could be enacted and enforced. Further, public education regarding the negative impact of these drinking practices should be carried out through school programs and media campaigns targeting all community members.

The third strategy emphasized by May (1992) focuses on reducing environmental risk. Some of these measures are increasing the use of passive restraints such as seat belts, air bags, and infant seats; promoting designated-driver and safe-ride programs; mandating server training; supporting domestic violence shelters; and focusing enforcement efforts on drinking establishments that produce the most public drunkenness and other alcohol-related problems.

There are several examples of these strategies in American Indian communities. Marum (1988) describes the community-generated prevention process with one program in Alaska. Public education on substance abuse was undertaken to increase the pool of knowledgeable and skilled people who would be working on preventing substance abuse. Specifically, the Alaskan efforts emphasized community mobilization and empowerment through volunteer networks to increase knowledge of substance abuse and interventions, community-wide awareness of substance abuse, alcohol and other drug education

for youth, problem solving at the local level, and increased involvement and empowerment of the elders.

Maynard and Twiss (1970) describe a pilot model community mental health program at Pine Ridge, South Dakota. Research was generated on social and environmental conditions that were related to mental health, substance abuse, and other health and behavioral health conditions. They describe the historical, demographic, economic, social, and cultural conditions among the Oglala Lakota (Sioux) at Pine Ridge and analyze their significance for behavioral health. A large part of their concern is related to alcohol and substance abuse. They make a number of suggestions for prevention that concentrate on community-wide structural issues. Maynard and Twiss advocate a major social and economic development program that eliminates dependent poverty through providing culturally approved employment opportunities on the reservation, upgrading the educational system, and fostering leadership through strengthening the authority and dignity of the tribal leadership and tribal council. Similarly, Macedo (1988) provides a primary prevention perspective on whole communities that are "injured" and traumatized by modern forces, particularly alcohol abuse. Macedo emphasizes the concept that these communities must first work through their collective trauma and then begin to develop their own internal interventions. May, Miller, and Wallerstein (1993) describe several steps that are useful in developing appropriate community-based prevention programs: (1) listen, (2) develop a relationship, (3) encourage dialogue, (4) avoid polarization, (5) provide a range of alternatives, and (6) help the community initiate options on its own.

Summary and Conclusion

As a group, American Indians experience many problems that are related to alcohol misuse. Alcohol-involved mortality data are worse for American Indians than overall U.S. averages. The age of first involvement with alcohol is younger, the frequency and amount of drinking is greater, and negative consequences

are more common for American Indian than non-Indian youths. The literature summarized in this chapter shows that programs do exist that are attempting to promote health in the face of the problem of alcohol misuse among American Indians. A theme that carries throughout this literature is that programs that address these issues, and thus the efforts of prevention workers, must take account of American Indian heterogeneity as it is reflected in tribal affiliation, cultural groups, language, and blood quantum. We must also take into consideration the young age composition of the American Indian population and the observation that the majority of American Indian people live off rather than on reservations.

What then are the principles that can be extracted from the material covered in this chapter? First, regarding principles that apply to the way prevention workers carry out their work in American Indian communities, there are several observations of importance. The main points are (1) programs must emerge from the community, (2) prevention workers must demonstrate a commitment to the community, and (3) non-community members need to develop cultural sensitivity.

Developing cultural sensitivity starts by becoming aware of one's own cultural values and then learning about differences relative to other cultures. A key point here is to avoid the urge to attempt to become a member of the community—to become an American Indian. Many jokes are made among American Indians about such people as being members of the *Wanabe Tribe*. Acquiring a deeper level of cultural sensitivity requires spending time in a community. However, entrèe to a community, at least at the program level, requires one to identify and negotiate access with appropriate gatekeepers such as tribal councils or representatives from key agencies. A central point in this negotiation is to demonstrate how the community is going to benefit from the program. The historical distrust of outsiders that is present in many American Indian communities is based at least in part on a history of programs that took more than they gave. This is an extremely sensitive issue in many American Indian communities.

Second, regarding the prevention approaches that are most appropriate in American Indian communities, several principles emerge. Use American Indian persons as staff whenever possible and incorporate cultural concepts within the programs. This latter point comes up over and over again. The challenge is how to do this in a meaningful way when culture varies across American Indian communities. Here the key is to design programs in a way that allows the content to be shaped and molded to fit the local culture. In addition, programs must assist people in their efforts at empowerment (Beauvais & LaBoueff, 1985). Prevention programs can be initiated by outside "experts" working with American Indian leaders, but individuals in the local community must continue the activities (Moran, 1995; OSAP, 1990). This does not mean that programs designed for one American Indian community cannot be transferred to others. It does mean that programs should be made relevant to local norms, values, and conditions through particular, culturally sensitive adaptations (May & Hymbaugh, 1989). A further principle derives from the observation that American Indian people live in two worlds: their American Indian community and the dominant society. Prevention workers should keep the concept of bicultural identity in the forefront and should structure programs in a manner that strengthens participants' ability to identify with and function in both of their worlds.

Always keeping the issue of adaptation to the specific culture in mind, prevention workers should promote a comprehensive community approach to prevention. The goal should be to apply comprehensive strategies and programs to reduce alcohol-related problems among total groups and aggregates of individuals (Beauchamp, 1980). The focus therefore is on communities and particular geographic areas and *not* on individuals. No single type of alcohol abuse prevention should be championed, but rather various programs and approaches should be fit or bound together in a mutually supportive and beneficial manner (May, 1992). Therefore, different levels of prevention dealing with a variety of alcohol-involved behaviors should be used and coordinated (Bloom, 1981; Manson, Tatum, & Dinges, 1982). For example, prevention efforts must have plans for involving and

strengthening the community and family. American Indian families that are strong and well integrated produce children with better indicators of adjustment and in most cases, fewer indicators of deviance (Jensen, Stauss, & Harris, 1977). Finally, all prevention programs, regardless of the focus, must ensure that the level of intervention is adequate and that interventions maintain fidelity across sites (Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995). Without these two conditions, we run the ultimate risk of underserving American Indian communities by not recognizing effective and culturally appropriate programs. The various approaches described in this chapter, then, are not at all mutually exclusive, but can be mutually supportive when orchestrated by a comprehensive community-wide plan and approach.

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